WMC Retrospective Research Findings and Early Insights

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I'm going to give you an overview, speed overview of our retrospective study. Let's start with the two goals of the study. One is to use quantitative data to investigate differences in patterns of medical utilization by variously defined subsets of our employees. Second, similar to the Lovelace Group, we also have a qualitative component, where we want to use qualitative data to investigate knowledge, attitudes, and resource utilization by stakeholder and by managers and supervisors in our study.

A little bit about our environment. We are a public university. We are, of course, if you read *U.S. News and Worlds Report,* the leading public university, tied with t he University of California at Berkeley, I believe. We employ approximately 14,000 people; we include a major medical center; we're located in a very small city, Charlottesville, Virginia, which means we are the major employer by a factor of about 100; and we are also a self-insurer through a UVA-created managed care company called Choice of Virginia.

First I'll tell you about our quantitative component so you won't hear any data at this point. This is way too early to risk putting out data. The goals of our quantitative component are to merge data from several sources; to then use that merge data to analyze the effects that are relevant to UVA; to share the data for the cross-site analysis; and to participate in the analysis and interpretation of the cross-site data. The data sources that we're merging, as has been noted by other speakers, are all highly confidential, sensitive data sources. This has been one of our main problems in obtaining the quantitative data -- dealing with concerns that verge on paranoia about what is going to happen to this data.

We're combining University of Virginia human resources data, looking primarily at that, as related to employment, such as employment status, length of employment, absenteeism and

accidents.

The Institute for Quality Health is an institute that was begun by UVA several years ago and now provides our employee wellness program, our employee assistance program, and our occupational health program. We are going to be using both, the health risk appraisal data base, and the data from the faculty of the employee assistance program.

Finally, we're using the data from the MCO, QualChoice of Virginia, to look at medical utilization. Our primary comparison was to compare medical utilization by subsets that are defined by service use. We have three primary categories. There's employees who made no use of IQ Health Services, those employees who made use of the HRA only, and those employees who made use of the Faculty and Employee Assistance Program. We also wanted to compare medical utilization of subsets of employees within those who use the HRA, defined by risk status. Finally, we want to look within employees who use the FEAP, to look at use for substance abuse problems, versus use for mental health problems; although our numbers are going to be incredibly small, as was noted again at by I think it was Lovelace, one of the other sites for use and substance abuse problems.

What I mainly want to put forward today is some of the difficulties we have encountered. I have already mentioned the difficulties with concerns about confidentiality. I will describe some of the other practical difficulties that we have encountered which we would recommend that you try to avoid. First of all, if at all possible, do not let the CEO of your managed care organization resign as you are starting to put this study together. The CEO of our study resigned about three months after he signed the cooperative agreement with us. The managed care organization that was there was understandably not willing to go forward until they had hired a new CEO and has his or her approval. We had quite a job convincing them to go forward with this agreement in the absence of a new CEO.

Also, just about when we got that straightened out, we had a major reorganization in UVA's

own human resource function, the hospital split off from the rest of the university and instituted their own human relations group. We then had to start negotiating for that data separately.

If you get beyond that, another good thing to avoid is finding out that some of the records that you want to merge are paper only. We had to undertake a massive computerization task to convert FEAP records from paper only into a computerized data base. This brought us face-to-face with incompatible computerized data bases. Since we're drawing data from multiple sources, which were begun at different times, using different formats, and combining them, maintaining the quality of the data presents some significant challenges.

We have also come across the problem of tremendous variability over quality, absenteeism data in particular. The problem is simple to state -- faculty absenteeism data is totally unreliable. So we have reliable data for classified employees, and virtually no data that we can rely on for absenteeism of faculty.

We also had variable, and on the whole, low participation rates in the HRA. Some of what I heard yesterday was reassuring in this, because it suggested that maybe we won't have as many problems with bias towards the healthy end of the spectrum as we though we might have. Our participation rates in our HRA runs from 25 to 35 percent, so they really are significantly low. In fact one of the goals of our prospective study is to enhance participation rates for HRA. We also had changes in the benefit structure during the time period of the study. We were doing a three-year retrospective study. In the first year, not all employees were required to have QualChoice as their insurer, by the last year, they all were; so we have differences in enrollment to deal with.

And as I mentioned, the problem that we run into time and time again is the confidentiality concerns, which especially with the human relations people, are very matched with concerns about liability. What will be their legal liability if action is taken against an employee for

substance abuse problems. They are very worried about that employee being able to say, "You pre-identified me through this combined data base, and you were watching me more carefully than you watched other people, so you were unfair to me."

To turn to our qualitative study, where I do have some data to present, the primary goal of our qualitative study was to understand the investment that our managers and supervisors and major stakeholders had in substance abuse prevention in the work place. In particular, we asked them about their experience with employee behavioral problems; their knowledge and use of available resources at UVA to help them deal with such problems. What un-met needs did they feel that they had as managers and supervisors to be able to deal with such problems? And finally, what were their attitudes towards substance abuse prevention in the work place? Did they believe in it or did they not believe in it?

We've identified very preliminarily, without doing a formal ethnographic analysis yet, some emerging themes. First of all, we have found that our Faculty and Employee Assistance Program is almost universally highly valued by managers and supervisors; if for no other reason than as one manager told us, "These are the employees we most want to get rid of, and they give us somebody to ship them to."

The FEAP program is seen as the expert in dealing with particularly different problem employees. By contrast, we found a great deal of doubt among managers and supervisors, and among our HR personnel about the value of the health risk appraiser, whether the employer or the employee. A very knowledgeable informant, in our human relations department, said to us, "It is not enough that a benefit be of value. A benefit has to be of perceived value -- a greater perceived value than something else that could be paid for with that cost."

That leads us to jump to my next point, the importance of the employee's perception of the value and benefit has been emphasized over and over again. Someone in the human relations

department estimated that the FEAP HRA benefits cost around $100-$120 per year per employee. She pointed out that was about the cost of a pass to our physical recreation facilities at the University of Virginia, and wondered if the employees wouldn't rather have the physical recreation than the HRA and the FEAP.

So over and over again, we have found our managers and supervisors saying to us, "The employees have to recognize that this is a value in order for it to be of value in the work place."

Now this took us by surprise. Especially on the academic side of the university. We met an unexpected degree of resistance of even participating in the interview, much less to the managers and supervisors assuming any responsibility for identification and intervention. They simply did not feel that was part of their role.

Related to that, we found that organizational differences within UVA greatly complicated service delivery. The medical side is much more structured than the academic side, with a different kind of corporate philosophy. It's more hierarchical, relationships tend to be better defined. We had similar differences related to faculty versus classified staff. We found out that the faculty don't really consider themselves employees. In fact, many take exception to being called an employee. And many have told us straight out, it doesn't matter what you do, we're not participating.

At another level, there is a difference between technicians and other faculty. This difference is revealed in very definitely in the way substance abuse problems among physicians, versus other health care providers, are treated. In the entire history of the FEAP, there has been possibly one, but they're not sure, they think it may be no physician ever referred to the FEAP. The FEAP is simply not used for physicians. Over again, managers in the health care side have emphasized to us the difficulty of reaching night shift employees. Night shift employees seem to have a somewhat different culture and, therefore, different problems than

dayshift employees.

The primary theme that we have heard, and we have identified over and over again, is that it's difficult to consider UVA as a single employee because there is such a lack of a uniform vision. When we met with the vice provost for the Health Sciences Center, located at one end of the UVA campus. The rest of the academic side is at the other edge, and in between is a drive called Hospital Drive. And he said to us, "Hospital Drive is the widest street in America. Everything is different on those two sides."

That kind of thinking and problem obviously impact a number of things we are interested in, including manager/supervisor training to deal with problems, policy development, commitment to intervention, and understanding the value of prevention and prevention to the employer and to the employee.

That's where we are right now. We're hoping to get our quantitative data soon. Thank you.